General Assembly

Raised Bill No. 6455

January Session, 2003

LCO No. **3281**

Referred to Committee on Public Health

Introduced by:
(PH)

AN ACT CONCERNING PATIENT RIGHTS AND MANAGED CARE SUBCONTRACTORS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2003*) (a) Any managed care organization, as defined in section 38a-478 of the general statutes, that contracts with a utilization review company, as defined in section 38a-226 of the general statutes, to provide services on behalf of the managed care organization, shall be liable for decisions made by such utilization review company. All rights of appeal or causes of action provided to an enrollee by a managed care organization shall also be available to an enrollee aggrieved by actions of a utilization review company that provides services on behalf of such managed care organization, and an enrollee may proceed directly against the managed care organization to contest the actions of such utilization review company.

Sec. 2. Section 38a-815 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2003*):

No person shall engage in this state in any trade practice which is

defined in section 38a-816 as, or determined pursuant to sections 38a-817 and 38a-818 to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance, nor shall any domestic insurance company engage outside of this state in any act or practice defined in subsections (1) to (12), inclusive, of section 38a-816. The commissioner **[**shall have power to**]** may examine the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by sections 38a-815 to 38a-819, inclusive. When used in said sections, (1) "person" means any individual, corporation, limited liability company, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society and any other legal entity engaged in the business of insurance, including producers and adjusters, (2) "the business of insurance" includes, but is not limited to, business conducted by a utilization review company, and (3) "utilization review company" has the same meaning as set forth in section 38a-226.

Sec. 3. (NEW) (*Effective October 1, 2003*) The Insurance Commissioner shall adopt regulations, in accordance with chapter 54 of the general statutes, to establish minimum capital and minimum surplus requirements for any utilization review company, as defined in section 38a-226 of the general statutes, that assumes from an insurer or health care center some or all of the risk to pay health insurance claims with respect to certain enrollees. Such requirements shall be similar to the requirements for insurers as set out in section 38a-72 of the general statutes.

Sec. 4. (NEW) (*Effective October 1, 2003*) (a) Every managed care organization, as defined in section 38a-478 of the general statutes, that contracts with a utilization review company, as defined in section 38a-226 of the general statutes, shall include in its contracts and agreements with such utilization review company, a provision that the utilization review company will include in all contracts between the

utilization review company and participating health care providers, a provision transferring and assigning contracts between the utilization review company and participating health care providers to the managed care organization for the provision of future services by participating health care providers to enrollees, at the discretion of the managed care organization, in the event the utilization review company fails to make payments previously authorized by such utilization review company, or becomes insolvent.

(b) Whenever the commissioner determines that (1) (A) a utilization review company has violated subdivision (15) of section 38a-816 of the general statutes, (B) the time period set forth in said subdivision (15) has elapsed, and (C) there has been a further thirty-day period of a pattern of nonpayment by the utilization review company of authorized claims, or (2) the utilization review company is insolvent, the commissioner, without notice and before applying to the court for any order, forthwith shall take possession of the capital reserves and any letters of credit or performance bonds of such utilization review company. The commissioner shall transfer such capital reserves, letters of credit and performance bonds to the managed care organization that contracted with the utilization review company to provide services on behalf of the managed care organization. The managed care organization shall make payments previously authorized by the utilization review company out of such reserves, letters of credit and performance bonds, and shall be liable for any such payments that exceed the amount of such reserves, letters of credit and bonds.

Sec. 5. (NEW) (*Effective October 1, 2003*) (a) Complaints regarding acts or practices of a utilization review company may be made by an enrollee, subscriber or provider to the Insurance Commissioner, the Office of the Managed Care Ombudsman or to the Attorney General. Such commissioner, office and Attorney General shall each compile a list of complaints received and, on a monthly basis, send each list to the other two entities, except the names of complainants shall not be disclosed if such disclosure would violate the provisions of section 4-

61dd or 38a-1045 of the general statutes.

(b) If such lists of complaints indicate that a utilization review company may have engaged in a pattern or practice that may be in violation of sections 38a-226 to 38a-226d, inclusive, of the general statutes, or sections 38a-815 to 38a-819, inclusive, of the general statutes, as amended by this act, the Attorney General may investigate and compel discovery for the purposes of such investigation regarding such utilization review company. The Attorney General may refer the results of such investigation to the Insurance Commissioner for appropriate administrative remedies, or may bring an action in the superior court for the judicial district of Hartford to enjoin any such act or practice and to recover a civil penalty as provided in subsection (c) of this section.

(c) Any person found, pursuant to an action brought by the Attorney General pursuant to subsection (b) of this section, to have violated any provision of sections 38a-226 to 38a-226d, inclusive, of the general statutes, or to have engaged in an unfair method of competition or an unfair or deceptive act or practice in the business of insurance shall be liable for one or both of the following: (1) Payment of a monetary penalty of not more than one thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of ten thousand dollars unless the person knew or reasonably should have known that the person was in violation of section 38a-815 of the general statutes, as amended by this act, or section 38a-816 of the general statutes, in which case the penalty shall be not more than five thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of fifty thousand dollars in any six-month period; and (2) restitution of any sums shown to have been obtained in violation of any of the provisions of sections 38a-226 to 38a-226d, inclusive, of the general statutes, sections 38a-815 to 38a-819, inclusive, of the general statutes, as amended by this act, or any regulation implementing the provisions of said sections.

(d) Any enrollee, subscriber or provider who is aggrieved by any utilization review company that has been engaged or is engaging in any practice or act defined in section 38a-816 of the general statutes as an unfair method of competition or an unfair or deceptive act or practice in the business of insurance in violation of sections 38a-815 to 38a-819, inclusive, of the general statutes, as amended by this act, may bring an action in the superior court, and the court may, in its discretion, award restitution of any sums shown to have been obtained in violation of any of the provisions of said sections or any regulation adopted pursuant to said sections, costs and reasonable attorneys' fees, damages and, in addition to damages or in lieu of damages, injunctive or other equitable relief.

Sec. 6. (NEW) (*Effective October 1, 2003*) No health insurer, health care center or utilization review company, as defined in section 38a-226 of the general statutes, shall take or threaten to take any health insurance or personnel action against any enrollee, provider or employee in retaliation for such enrollee, provider or employee (1) disclosing information to the Insurance Commissioner or Attorney General concerning any practice defined in section 38a-816 of the general statutes as an unfair method of competition or an unfair and deceptive act or practice in the business of insurance, (2) filing a complaint with the Office of the Managed Care Ombudsman, or (3) filing an action under subsection (c) of section 38a-819 of the general statutes, as amended by this act. Any enrollee, provider or employee who is aggrieved by a violation of this section may bring a civil action in the superior court to recover damages and attorneys' fees and costs.

This act shall take effect as follows:	
Section 1	*October 1, 2003*
Sec. 2	*October 1, 2003*
Sec. 3	*October 1, 2003*
Sec. 4	*October 1, 2003*
Sec. 5	*October 1, 2003*
Sec. 6	*October 1, 2003*

Statement of Purpose:

To provide protections for insureds who are provided with health care services through subcontractors of managed care companies.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]